VA'S KEY PERFORMANCE MEASURES

This section of the report presents the performance goals and measures VA management considers critical to the success of the Department. Some of these deal with program outcomes; others relate to the management of our programs. The presentation is structured around new strategic goals and objectives drafted in FY 1999.

While some of the key measures support achievement of more than one strategic goal or objective, we have aligned them with the strategic goal and objective that they most closely support. For each of the key performance goals, we present salient information:

- ❑ The strategic goal and objective with which it is aligned.
- ❑ The performance measure or measures used to gauge progress toward achieving the goal and objective.
- ❑ Historical data.
- ❑ Means and strategies used to determine the actual level of performance.
- ❑ Crosscutting activities with other federal and private organizations.
- ❑ Descriptions of any relevant management challenges affecting goal achievement.
- ❑ Source of the performance information and how it was validated.

Other goals and measures deemed important by the program offices continue to be monitored, and are presented in the data tables beginning on page 59.

1. STRATEGIC GOAL

Restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families. Maximize the ability of disabled veterans, special veteran populations, and their dependents and survivors to become full and productive members of society through a system of health care, compensation, vocational rehabilitation, life insurance, dependency and indemnity compensation, and dependents and survivors education.

Objective 1.2

Improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.

Performance Goal

VA is in the process of developing outcomes and performance measures for the dependency and indemnity compensation (DIC) programs; as a result, there were no performance goals for FY 1999.

Means and Strategies

VA published a set of interim outcomes with the FY 2000 Budget in February 1999 as a means of stimulating discussion about the purpose of the compensation program and appropriate ways to measure its success with our stakeholders. In July 1999, the Director of the Compensation and Pension (C&P) Service started a series of consultation sessions with veterans service organizations, House and Senate Veterans' Affairs Committee staff, OMB staff, and representatives from other VA activities.

During the first session, attendees explored possible program purposes, a variety of outcomes, and the types of data needed to demonstrate the extent to which the program

is achieving its outcome goals. They identified a large number of purposes and outcomes. Program experts used the results of the first consultation session to draft a new mission statement and a smaller set of purposes.

These sessions will continue into FY 2000. We expect to have the outcomes and measures determined for use during the FY 2002 Budget formulation process.

On July 9, 1999, VA awarded a contract to Systems Flow, Inc., to perform an objective, third-party study of Benefits for Survivors of Veterans with Service-Connected Disabilities. This program evaluation, to be completed during FY 2000, will provide essential information about the DIC program outcomes and measures, and supports our objective to ensure survivors of service-disabled veterans are able to maintain at least a minimum standard of living.

Data Source and Validation
While VA has data on veterans' satisfaction with the compensation and pension claims process, we do not yet have data on the impact the programs have on the quality of veterans' lives.

Objective 1.3
Enable service-disabled veterans to become employable, and to obtain and maintain suitable employment.

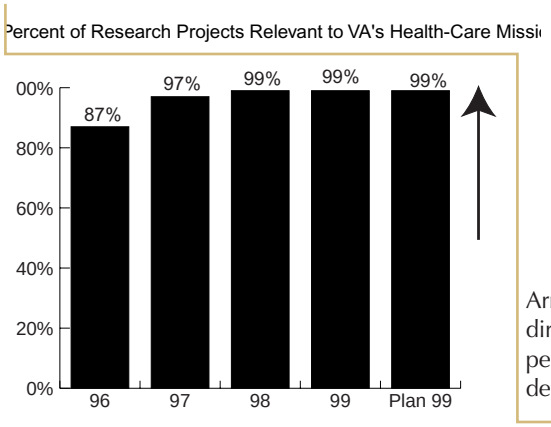
Performance Goal
At least 45 percent of all veteran participants who exit the vocational rehabilitation program will be rehabilitated.

VA exceeded its annual target by a significant margin. During the past three years, we have seen substantial progress in assisting more veterans to achieve suitable employment. The number of veterans who completed their programs of rehabilitation and reentered the job market increased from 7,400 during FY 1996 to 10,300 during FY 1999. A veteran is rehabilitated when he or she is able to acquire and maintain suitable employment after completing a rehabilitation program.

Our stakeholders, especially in Congress, GAO, the Veterans' Advisory Committee on Rehabilitation, and the Commission on Veterans and Servicemembers Transition Assistance, have voiced concerns in seven areas. During the past year, our program leadership analyzed those concerns and identified the following major challenges:

1. Focus on employment.
2. Realign customer perceptions and expectations with the program's intent.
3. Improve monitoring of outcomes and feedback to the program.
4. Improve information technology support for the program.
5. Improve access for veterans.
6. Foster coalitions with peer organizations and partners.
7. Improve business process inefficiencies.

Means and Strategies
In the past, veterans and stakeholders viewed the vocational rehabilitation program as an education program rather than one geared toward employment. During FY 1999, we began redirecting our focus. We are pursuing a staff training strategy of increasing our expertise in employment markets, trends, and job placement. To reduce the attrition



Arrow indicates direction in which performance is desirable.

rate, we are improving our information systems to better understand why participants drop out of the program.

We are redesigning our communication and outreach tools, so veterans can better understand the intent of the program—providing rehabilitation services geared toward gaining suitable employment. Each veteran is now assigned a vocational rehabilitation counselor, who serves as his or her case manager, to provide guidance in achieving the veteran's rehabilitation goal. We are in the process of redesigning our forms, applications, and information brochures to emphasize the employment focus of the program.

Because successful rehabilitation requires a close relationship between veteran and counselor, the providers must be where veterans can access the services. We are working on several initiatives to increase the places and means of access for veterans. Where the population warrants it, we assign counselors to locations away from regional offices. We provide information technology so that counselors can access our databases from any location. We have increased our use of contract counseling so that we can serve more veterans with shorter waits.

Crosscutting Activities
VA partners with the Department of Labor to improve the number of veterans who obtain suitable employment and reduce the amount of time veterans are in the job-seeking process.

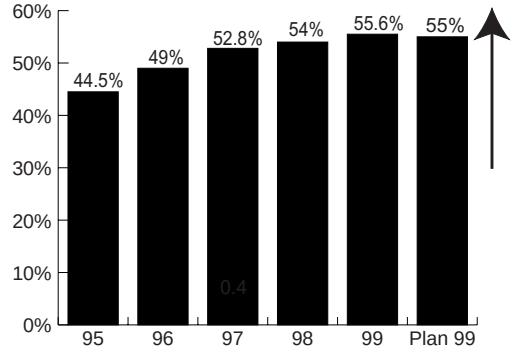
Data Source and Validation
Data are collected at regional offices and entered into the Benefits Delivery Network case status system. Vocational Rehabilitation & Counseling (VR&C) program staff validate the data during semi-annual case reviews.

2. STRATEGIC GOAL
Ensure a smooth transition for veterans from active military service to civilian life. Veterans will be fully reintegrated into their communities with minimum disruption to their lives through employment services, including vocational rehabilitation; education assistance; home loan guaranties; life insurance; and transitional health care and readjustment counseling services.

Objective 2.2
Assist veterans in readjusting to civilian life by restoring lost educational opportunities and enhancing their ability to achieve educational and career goals.

Performance Goal
Improve the Montgomery GI Bill (MGIB) active duty usage rate to 55 percent.

Montgomery GI Bill Usage Rate



VA met its performance goal to increase the MGIB usage rate. The extent to which eligible beneficiaries use their earned benefit is one measure of program success. A greater number of veterans using the MGIB will contribute to a more highly educated and productive workforce, thus enhancing the Nation's competitiveness. Veterans use the benefit to readjust to civilian life and achieve educational or vocational objectives that might not have been attained had they not entered military service. The Department of Defense (DoD) uses the educational benefits under the MGIB as a successful recruiting tool.

Means and Strategies
The usage rate improved, at least in part, because we improved our access, our outreach to servicemembers and veterans, and our claims processing technology.

Education beneficiaries throughout the Nation now receive toll-free telephone service by dialing 1.888.GIBILL1 (1.888.442.4551). They are first connected to an automated response system (ARS) that provides general information; answers to frequently asked questions; recent payment information; and limited, beneficiary-specific, master record information. Callers can opt to speak to an Education Case Manager at any time during the call if personal attention is desired.

VA's Education Service mailed out a cover letter and brochure, "Focus on Your Future With the Montgomery GI Bill," to men and women in the Armed Forces. The pamphlet provided a general description of VA education benefits. It included information to help servicemembers, who might be eligible for MGIB benefits, in making a decision to enter training.

VBA is testing two interactive Internet applications designed to improve service to veterans and to facilitate information exchange between education institutions and VA. Web Automated Verification of Enrollment will allow MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form to VA. By eliminating mail time, veterans will receive their monthly benefits more quickly than in the past. The second application, VA Internet Certification, will provide an Internet vehicle for school certifying officials to submit student enrollment information to VA. Both applications will reduce the amount of paper coming to the regional processing offices and speed the benefit payment process, thus encouraging veterans to use their benefits.

A program evaluation of the MGIB program is nearing completion. Among the research questions explored by the Klemm Analysis Group, an independent contractor, is an objective assessment of the degree to which the MGIB benefit has assisted program users to achieve educational and career goals.

Crosscutting Activities
Increasing the MGIB usage rate requires coordination between VA and organizations currently performing, or planning to perform, outreach activities. In addition to this partnering, a coordinated effort with DoD is underway to identify eligible service personnel and to build upon existing base counseling and outreach activities at military bases. State approving agencies and other stakeholders provide a presence in remote locations.

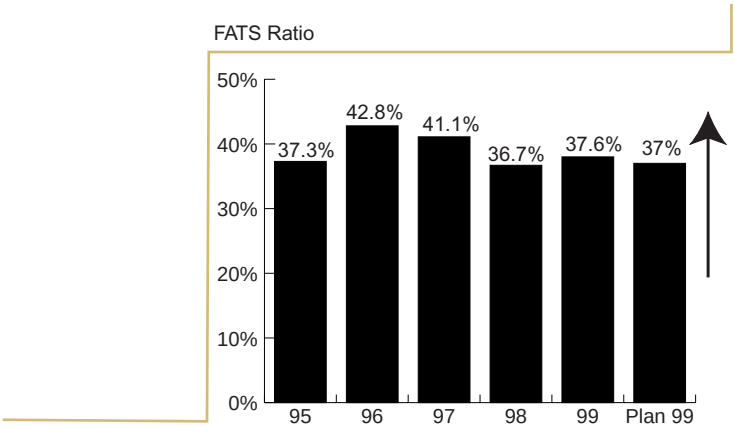
Data Source and Validation
The MGIB usage rate is calculated by dividing the cumulative number of individuals who began a program of education under the MGIB by the overall number of potentially eligible veteran beneficiaries.

VA tabulates the annual usage rate, using DoD's Defense Manpower Data Center separation records and veteran student data from VBA's Education Master Record File. We do not independently validate the DoD information.

Objective 2.3
Improve the ability of veterans to purchase and retain a home through a loan guaranty program.

Performance Goal
Improve the foreclosure avoidance through servicing (FATS) ratio to 37 percent.

VA met its goal to assist veterans who are in default of a VA-guaranteed home mortgage as measured by the FATS ratio. This measures the extent to which foreclosures would have increased had VA not pursued alternatives to foreclosure. Alternatives to foreclosure can help veterans either save their home or avoid damage to their credit rating, while reducing costs to the Government.



Means and Strategies
There are four alternatives to foreclosure:

1. **Successful intervention**–VA may intervene with the holder of the loan on behalf of the borrower to set up a repayment plan or take other action that results in the loan being reinstated.

2. **Refunding**–VA may purchase the loan when the holder is no longer willing or able to extend forbearance, but VA believes the borrower has the ability to make mortgage payments, or will have the ability in the future.

3. **Voluntary conveyance**–VA may accept the deed in lieu of foreclosure from the borrower if it is in the best interest of the Government.

4. **Compromise claim**–If a borrower in default is trying to sell the home, but it cannot be sold for an amount greater than or equal to what is owed on the loan, VA may pay a compromise claim for the difference in order to complete the sale.

To improve VA's ability to assist veterans who are delinquent on their mortgages, we are implementing state-of-the-art information technology designed for this specific purpose. Success in loan servicing requires person-to-person contact with the veteran, usually by telephone. There is a need to automate default servicing and foreclosure management so that VA staff can help veterans avoid foreclosure.

This system tracks the variety of actions taken by VA, lenders, and borrowers during the default period. It automates routine and redundant activities, improving efficiency and allowing employees to concentrate on supplemental loan servicing. It will also allow for an earlier analysis of the appropriateness of the different alternatives to foreclosure.

Aggressive outreach is often a necessary component of our servicing efforts, to convince defaulted borrowers of the seriousness of their situation and prod them to take action to avoid a foreclosure. During FY 1999, VA made nearly 224,000 servicing contacts with veterans in an effort to help them avoid foreclosure.

Throughout the course of FY 1999, VA has continued its efforts to consolidate loan guaranty functions to the regional loan centers. This was accomplished with no adverse impact on our ability to meet our performance targets. Because of this restructuring, we are better positioned to meet future performance targets.

Major Management Challenges
The servicing system was implemented in FY 1999. However, it supports only the basic business process. It does not have the functionality to support the full range of changes in lending industry practices or the restructuring of field operations. Enhancements to the basic system are needed to ensure veterans receive timely and complete service when they are seriously delinquqent on their guaranteed mortgages. The planned upgrade will increase the utility of the system, provide more accurate data for workload management, and improve service to veterans and the lending industry.

Data Source and Validation
Data to calculate the FATS ratio come from the Loan Service and Claims system. The IG is currently conducting an audit of the system

and data that produce the FATS ratio as part of the effort to assess the data quality of VA's key measures. The IG will report its findings during FY 2000.

3. STRATEGIC GOAL

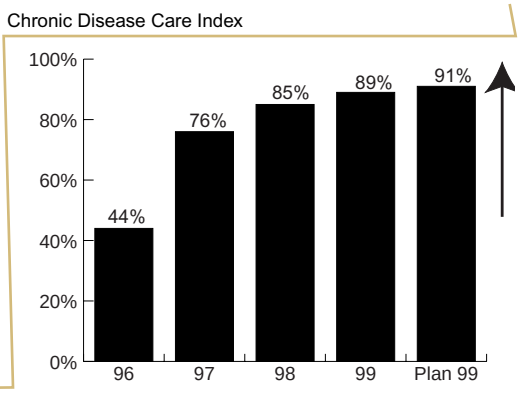
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation. Veterans will have dignity in their lives, especially in time of need, through the provision of health care, pension programs and life insurance, and the Nation will memorialize them in death for the sacrifices they have made for their country.

Objective 3.1

Improve the overall health of enrolled veterans, including special populations of veterans, through high-quality, safe, and reliable health services.

Performance Goal 1

Increase the score on the Chronic Disease Care Index (CDCI) to 91 percent.



Consisting of 13 clinical interventions, the CDCI measures the degree to which VA follows nationally recognized guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity. The CDCI is one of the primary quality of care measures used by the Department.

Investment in effective chronic disease management results in improved health of veterans and reduced use of services. Since a large percentage of veterans seek care for one or more chronic diseases, improved management of chronic disease results in reduced inpatient costs, admissions, and lengths of stay.

While VA fell short of its FY 1999 goal, performance improved over the previous fiscal year. The slight deviation between actual and planned performance did not affect overall program effectiveness. Eight of the 22 Veterans Integrated Service Networks (VISNs or networks) recorded CDCI scores that met or exceeded the national performance goal of 91 percent; 21 of the 22 VISNs had a score of at least 84 percent; the lowest CDCI score for a VISN was 79 percent.

Over the last three years, VA increased its CDCI score from 44 percent to 89 percent. Where comparable data exist, VA has consistently outperformed the private sector. Examples include the rate of aspirin therapy for patients following a heart attack (97 percent vs 78 percent); VA's 67 percent rate of retinal eye exams for diabetics, which exceeds the 1998 National Committee for Quality Assurance (NCQA) national average of 41 percent; and the percentage of diabetics whose blood sugar level is monitored annually by a blood test (93 percent vs 38 percent).

Means and Strategies

During FY 1999, the 22 networks emphasized specific strategies that contributed to the increase in the CDCI. For example:

- ❑ Many VISNs and facilities emphasized patient education and the development of additional patient education programs.
- ❑ Networks documented interventions and outcomes to reinforce quality patient care.
- ❑ The expanded use of clinical guidelines has ensured the standards of care provided anywhere in the network are comparable and of the highest quality.

- ❑ Staff clinical education programs proved their worth, and networks plan to offer them in the future. Staff education has improved through monthly performance monitoring by peer oversight such as the Performance Oversight Group, which uses a predetermined checklist.

To emphasize the importance of continuous improvement in quality of care as measured by the CDCI, the Under Secretary for Health included this measure in the individual performance plans of the 22 network directors.

VA will continue to examine strategies to improve the systems supporting the provision of high-quality care. In the future, implementing the automated medical records system and a system of clinical prompts and reminders will facilitate care delivery at the point of patient contact. The index will also remain part of the network directors' performance plans for FY 2000. Given these steps, additional increases in system-wide performance are anticipated.

Started in FY 1999 and scheduled for completion in mid FY 2001, VA has undertaken a comprehensive evaluation of cardiac care programs. This evaluation will address the full range of treatment, from prevention through acute and long-term care and bypass and transplant procedures, and focus on ischemic heart disease.

Crosscutting Activities

In conjunction with DoD, VA has implemented clinical practice guidelines with a long-range view toward ensuring continuity of care and a seamless transition for patients moving from one health-care system to the other. Clinical practice guidelines are recommendations for the performance or exclusion of specific procedures or services derived through rigorous methodological approaches.

Data Source and Validation

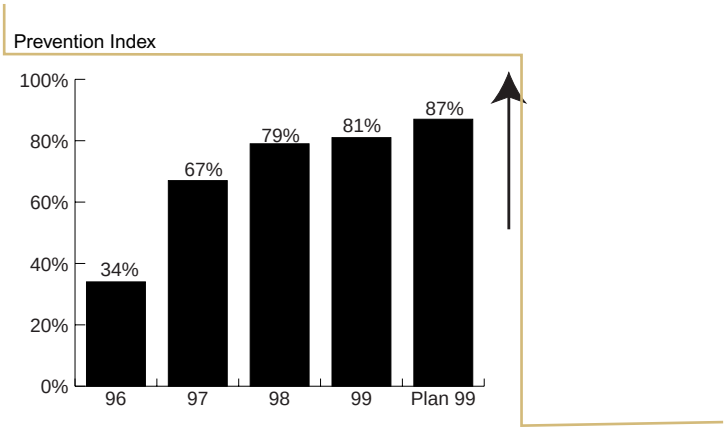
VA's External Peer Review Program (EPRP) is the source of the data for the CDCI. EPRP's contracted, on-site review of clinical records, is specifically designed to collect data for improving the quality of care delivered throughout the VA health-care system. EPRP serves as a functional component of the facility, VISN, and headquarters quality management program by:

- ❑ Providing information for use in VA's continuous quality improvement program.
- ❑ Identifying opportunities for improvement in care.
- ❑ Establishing a database for the analysis and comparison of patterns of care at all levels.

Data are abstracted monthly. The West Virginia Medical Institute conducts measurements of performance through medical record abstraction. The data are statistically evaluated to ensure validity and reliability. To further ensure validity and reliability of the data, ongoing inter-rater reliability assessments are performed quarterly for each abstractor involved in the review process. The data files and special performance reports collected by a subcontractor are generated for each quarter of the fiscal year and transmitted electronically to VA.

Performance Goal 2

Increase the score on the Prevention Index (PI) to 87 percent.



Consisting of nine clinical interventions, the PI measures the degree to which VA follows

nationally recognized primary prevention and early detection recommendations for eight diseases or health factors that significantly determine health outcomes: pneumococcal pneumonia, influenza, tobacco consumption, alcohol consumption, and screening for colorectal cancer, breast cancer, cervical cancer, and prostate cancer. The PI is another primary quality of care measure used by the Department.

VA provides primary, secondary, and tertiary preventive interventions that are important for healthy as well as severely ill and disabled veterans. Data contained in the PI are estimates of the average percentages of patients receiving appropriate medical intervention for these diseases or health factors, whether in the form of immunizations, screening, or counseling. These measures were initially reported only for primary care clinics. Over time, both the implementing and reporting of such measures were expanded to include related specialty clinics. The PI reflects VA's overall performance across all nine medical interventions.

While VA fell short of the FY 1999 goal, performance improved over the previous fiscal year. Three of the 22 VISNs registered PI scores that met or exceeded the national performance goal of 87 percent, and 19 of the 22 VISNs achieved scores of 79 percent or above. The deviation between actual and planned performance did not significantly affect overall program effectiveness. The performance target was based on very few historical data points. As additional time series performance data become available, the precision of our projections will increase.

Over the last three years, VA increased its PI score from 34 percent to 81 percent. In fact, the Washington, DC, VA Medical Center received the Vice President's Hammer Award for screening patients with a high risk for prostate cancer.

VA outperformed the private sector on all indicators where comparable data exist. For example, 93 percent of appropriate patients were counseled for tobacco consumption, whereas the comparable rate in the private sector was 63 percent. In addition, VA has surpassed the U.S. Public Health Service's "Healthy People 2000" goals in five of the eight prevention indicators for which comparative data exist: immunizations for pneumococcal disease and influenza, and screenings for colorectal cancer, breast cancer, and cervical cancer. Screening rates for breast and cervical cancer, 91 percent and 94 percent, respectively, exceeded the 1998 NCQA national average performance (72 percent and 70 percent, respectively) as well as the "Healthy People 2000" goals (60 percent and 85 percent, respectively).

Means and Strategies

Most diseases that cause disability or death among Americans could be prevented or delayed through screening, education, and counseling aimed at identifying risk factors and modifying behavior. Through its education programs and screening tests, VA helps veterans to become aware of ways in which health can be enhanced. The goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the burdens associated with the suffering and cost in disease management.

Low-cost preventive medicine is known to prevent early death and stave off the effects of debilitating diseases. A national study based on data from the Federal Medicare program shows less than 30 percent of women between the ages of 65 and 69 are getting mammograms every two years to detect breast cancer; and less than one-fourth benefit from colon cancer screening. Vaccines that can help prevent pneumonia, one of the leading causes of death among the elderly, are similarly underutilized. In contrast to the national picture, VA has implemented a system to maximize the use of these simple, yet extremely important, preventive measures.

Using the PI, VA evaluates progress toward improving systems that support preventive

care delivery. For example, the automated medical records system and a system of clinical prompts and reminders facilitate care delivery at the point of patient contact. To implement prevention services effectively, VISNs adopted a variety of strategies in FY 1999:

- ❑ Continued implementation of new clinical guidelines and refinement of existing guidelines.
- ❑ Development and implementation of patient and staff education programs on the benefits of prevention.
- ❑ Monthly monitoring of local performance, using checklists to ensure preventive activities were accomplished.
- ❑ Charging primary care teams with responsibility and accountability for local PI measures.

To emphasize the importance of continuous improvement in quality of care as measured by the PI, the Under Secretary for Health included this measure in the 22 network directors' individual performance plans.

Crosscutting Activities
In conjunction with DoD, VA has developed and implemented clinical practice guidelines with a long-range view toward ensuring continuity of care and a seamless transition for a patient moving from one health-care system to the other. The clinical practice guidelines are recommendations for the performance or exclusion of specific procedures or services that are derived through rigorous methodological approaches.

Data Source and Validation
VA's External Peer Review Program (EPRP) is the source of the data for the PI. EPRP is a contracted, on-site review of clinical records, specifically designed to collect data for improving the quality of care delivered throughout the VA health-care system. EPRP serves as a functional component of the facility, VISN, and headquarters quality management program by:

- ❑ Providing information for use in VA's continuous quality improvement program.
- ❑ Identifying opportunities for improvement in care.
- ❑ Establishing a database for the analysis and comparison of patterns of care at all levels.

Data are abstracted monthly. The West Virginia Medical Institute conducts measurements of performance through medical record abstraction. The data are statistically evaluated to ensure validity and reliability. To further ensure validity and reliability of the data, ongoing inter-rater reliability assessments are performed quarterly for each abstractor involved in the review process. The data files and special performance reports collected by a subcontractor are generated for each quarter of the fiscal year and transmitted electronically to VA.

Objective 3.2
Provide a level of income that brings veterans and their survivors up to a standard of living that assures dignity in their lives.

Performance Goal
VA is in the process of developing pension program outcomes and performance measures for the veterans and survivors pension program; as a result, there were no performance goals for FY 1999.

Means and Strategies
Program executives decided to concentrate their efforts on developing outcomes and measures for the compensation program before beginning work on pension program outcomes and measures. They chose compensation first because it is the biggest program and the one with the most stakeholder interest. We expect to initiate this task in FY 2000, but do not have a projected completion date.

Data Source and Validation
VA does not currently have data to measure how veterans and survivors perceive the pension program or the impact on the quality of their lives.

Objective 3.3
Enhance the financial security for veterans' families through life insurance and other benefits programs.

Performance Goal
VA is in the process of developing outcomes and performance measures for the insurance program; as a result, there were no performance goals for FY 1999.

VA published a set of interim outcomes for the FY 2000 Budget in February 1999 as a means of stimulating discussion with the Department's stakeholders about the purpose of the insurance program and appropriate ways to measure its success. In FY 1999, VA began gathering data for the interim outcomes. We will conduct consultation meetings with our stakeholders on outcomes during FY 2000. In addition, VA is conducting a program evaluation of insurance programs, to consider interim outcomes and propose new outcomes, measures, and systems for gathering this performance information. The evaluation will be completed during FY 2000.

Means and Strategies
There are three VA insurance programs for which outcomes are being developed:

1. **Veterans Mortgage Life Insurance (VMLI)**-Provides mortgage life insurance to severely disabled veterans at standard premium rates.

2. **Service-Disabled Veterans Insurance (S-DVI)**–Enables disabled veterans to obtain life insurance at standard premium rates, regardless of their service-connected impairments, for a reasonable time period following establishment of service connection for a disability.

3. **Servicemembers Group Life Insurance (SGLI) and Veterans Group Life Insurance (VGLI)**–Places servicemembers and reservists separated from duty on par with those who did not serve by enabling them to purchase insurance at premium rates competitive with those that healthy individuals could obtain; and by providing insurance coverage options comparable to group life insurance offered by large-scale employers to their civilian employees.

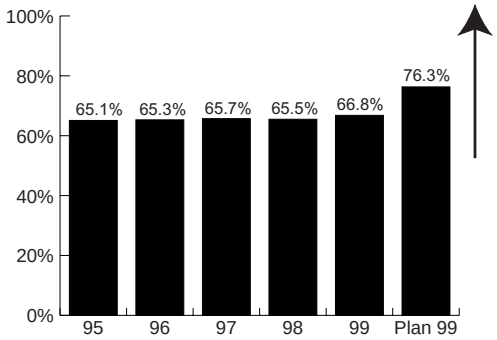
These outcome performance measures and the program evaluation will also support our objective to ensure that servicemembers and reservists separated from duty can convert or purchase life insurance at competitive rates.

Data Source and Validation
VA does not currently have data to measure how veterans and survivors perceive the insurance program or the impact on the quality of their lives.

Objective 3.4
Ensure the burial needs of veterans and eligible family members are met.

Performance Goal
Increase the percentage of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 76.3 percent.

Percentage of Veterans Served by a Burial Option



At the end of FY 1999, only 58 of the 116 existing national cemeteries contained available, unassigned gravesites for the burial of both casketed and cremated remains; 33

accepted only cremated remains, and remains of family members for interment in the same gravesite as a previously deceased family member; and 25 only performed interments of family members in the same gravesite as a previously deceased family member. As cemetery service capabilities decrease, veterans served by those cemeteries lose access to a burial option located within a reasonable distance of their homes.

Two new national cemeteries, Abraham Lincoln National Cemetery and Dallas/Fort Worth National Cemetery, did not open in FY 1999 as planned because of construction delays. Together they will provide a burial option to over 1.4 million veterans that are not currently served. Primarily as a result of the delay in opening these two cemeteries, the percentage of the veteran population served by a burial option within a reasonable distance from their home, 66.8 percent, was less than the performance goal of 76.3 percent. However, Abraham Lincoln National Cemetery did open in October 1999, and Dallas/Fort Worth National Cemetery is expected to open in FY 2000. VA is also constructing a new national cemetery in the vicinity of Cleveland, Ohio. When open, this national cemetery will provide a burial option for about 500,000 veterans not currently served.

More veterans were served by a burial option in FY 1999 than in FY 1998. During FY 1999, interment operations began at the new Saratoga National Cemetery in upstate New York, providing a burial option to 230,000 previously unserved veterans.

Workload Indicators	1995	1996	1997	1998	1999	Plan 1999
Number of interments in national cemeteries	70,557	71,786	73,007	76,718	77,680	79,700
Developed acres maintained	5,410	5,630	5,843	6,095	6,187	6,474
Annual number of existing national cemeteries expanded	6	7	3	7	4	13
Annual number of national cemeteries acquiring land	3	3	3	5	2	8

The workload indicators, as shown on the chart, demonstrate the volume and scope of NCA operations. NCA projects the number of interments in national cemeteries and the number of developed acres maintained using a variety of factors, including the number of national cemeteries performing interments. Because two new national cemeteries did not open as planned, the number of interments and developed acres maintained was less than planned. However, as previously mentioned, these two cemeteries are expected to open in FY 2000, and future performance will not be affected.

Means and Strategies

To better meet the burial needs of veterans, VA opened a new national cemetery in an unserved area; expanded four existing national cemeteries; acquired additional land at two national cemeteries; developed more effective use of available burial space; and expanded a pilot project to evaluate an alternative burial option for veterans and their eligible dependents.

Where feasible, national cemeteries are expanded by developing existing cemetery land for burial operations. VA monitors gravesite usage and projects gravesite depletion dates at open national cemeteries that have land for future development. As those cemeteries approach their gravesite depletion dates, VA ensures that construction to make additional gravesites or columbaria available for burials is completed. In FY 1999, VA completed construction projects at Dayton, Fort Rosencrans, Port Hudson, and Fort Sam Houston National Cemeteries. Although not all planned expansion projects have been completed, eight projects are in various stages of construction. An expansion project at one cemetery has been delayed until negotiations to obtain additional land are concluded. These delays will have no effect on future performance. No veteran was denied reasonable access to a burial option because of delays in expansion projects.

Appropriate land acquisition is a key component to providing continued accessibility to burial options. In FY 1999, VA acquired land to continue operations at Bath and Fayetteville National Cemeteries. VA will continue to identify national cemeteries that are expected to close because of depletion of grave space; and will determine the feasibility of extending the service life of those cemeteries by acquiring adjacent or contiguous land. These actions, which depend on such factors as the availability of suitable land and the cost of construction, are not possible in every case. Efforts to acquire additional land are currently underway at nearly a dozen national cemeteries. These delays will have no effect on future performance. No veteran was denied reasonable access to a burial option because of delays in acquiring land.

VA is exploring alternative burial options to provide service to those veterans who would not otherwise be served. NCA has launched a pilot project in which closed national cemeteries, in areas not served by an open national or state veterans cemetery, are used to provide committal services for eligible individuals, with subsequent interment in a more distant national cemetery. This option allows families the comfort of having the committal service for loved ones performed at a national shrine, while avoiding travel to a distant national cemetery.

External Factors

Abraham Lincoln National Cemetery, near Chicago, Illinois, was originally scheduled to open in FY 1999. The target completion date was not met because of construction delays resulting from inclement weather and revisions to the cemetery entrance configuration. The new cemetery was dedicated in a formal ceremony on October 3, 1999.

VA also planned to open the Dallas/Fort Worth National Cemetery in FY 1999. Because of construction delays, this target date was not met. VA is redoubling its efforts to ensure every opportunity is taken to expedite the completion of this new national cemetery, which is expected to open in FY 2000.

Crosscutting Activities

To complement our system of national cemeteries, VA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries. Serving 2.6 million veterans, a total of 38 operating state veteran cemeteries have been established, expanded, or improved through SCGP. In FY 1999, a grant was awarded to Massachusetts for the establishment of a new state veterans cemetery.

Data Source and Validation

The percentage of veterans served by a burial option within a reasonable distance of their residence was determined by analyzing census data, the number of new national or state veterans' cemeteries opened, and changes in the service delivery status of existing cemeteries. (Multiple counts of the same veteran population are avoided in cases of service-area overlap.)

The IG completed an audit assessing the accuracy of data used to measure the percent of the veteran population served by a burial option within a reasonable distance of place of residence. Audit results showed NCA personnel generally made sound decisions and accurate calculations in determining the percent of veterans served by a burial option. Although some inconsistencies in NCA's estimate of the percent of the veteran population served by a burial option were identified, they did not have a material impact, and no formal recommendations were made. VA has addressed these inconsistencies, and the adjustments are included in the data contained in this report.

4. STRATEGIC GOAL

Contribute to the public health, socio-economic well being and history of the Nation. VA will support the public health of the Nation as a whole through medical research, medical education and training, and serve as a resource in the event of a national emergency or natural disaster; VA will support the socio-economic well being of the Nation through education, vocational rehabilitation, and home loan programs; and VA will preserve the memory and sense of patriotism of those who served the Nation by maintaining national cemeteries as national shrines, and hosting patriotic and commemorative ceremonies and events.

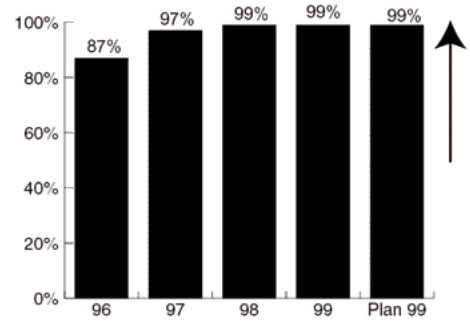
Objective 4.1

Advance VA medical research and development programs to better address the needs of the veteran population and to contribute to the Nation's knowledge of disease and disability.

Performance Goal

The share of funded research projects relevant to VA's health-care mission in Designated Research Areas (DRA) will remain at 99 percent.

Percent of Research Projects Relevant to VA's Health-Care Mission



For the second consecutive year, 99 percent of VA's funded research projects were demonstrably related to the health care of veterans or to other Departmental missions. Projects with VA health-care relevance were selected for funding before projects without demonstrable relevance.

Means and Strategies

VA's Research and Development (R&D) program benefits not only veterans but all Americans as well as the international community. The scope of the VA research portfolio extends from basic laboratory research on the cause, treatment, and cure of a variety of diseases, disorders, and disabilities to clinical research on patient care management. Many modern medical technologies, including the cardiac pacemaker, the CT scan, magnetic resonance imaging, and drug therapy for the mentally ill, have their roots in VA research.

Four research services work to meet the mission of the VA research enterprise: (1) the Cooperative Studies Program, one of the most important large-scale clinical trial programs in the world, provides evidence on the effectiveness of new or unproved therapies; (2) the Health Services Research and Development Service examines the organization, financing, and management of health care as well as their effects on health-care delivery, quality, cost, access, and outcomes; (3) the Medical Research Service provides knowledge of fundamental biological processes to expand our understanding of disease pathology; (4) the Rehabilitation Research and Development Service strives to minimize disability and restore function in veterans disabled by trauma or disease.

During FY 1999, new clinical trials, trials in planning, epidemiology studies, program announcements, training, and partnerships were established by the four research services. The following are a few examples of those efforts: VA funded three studies to look at the impact on practice of important findings published in journals and presented at national meetings; continued to work to find answers for Gulf War veterans (the subject of three studies); and planned or continued work on three national epidemiology studies through the Epidemiology Research Information Centers.

The pursuit of excellence in many ways boils down to the pursuit of new knowledge. That

is why research is so important to VA's mission of improving the health of America's veterans. Without the continued breakthroughs and innovations that have come out of our R&D program, VA's commitment to deliver excellence in health-care service and value would be undermined. The following are examples of medical advances to which VA contributed in FY 1999:

- Each year, more than 500,000 Americans experience rashes, blisters, and severe pain as a result of shingles. VA began conducting a groundbreaking shingles study, a major step toward developing a vaccine for this painful disease.
- A team of researchers from the Seattle, Washington, VA Medical Center (VAMC) accomplished what scientists had been trying to do for nearly two decades–keep stem cells alive in a laboratory setting.
- In a study funded by VA and the National Institute on Aging, investigators from the Honolulu VAMC uncovered a possible link between low-fat diets and the onset of dementia in stroke victims.
- Doctors from VA and Stanford University began looking into replacing painful needle immunizations with a vaccine that can be rubbed into the skin, thus easing patient fears.
- VA researchers reported findings from the first large-scale, long-term clinical trial to prove that raising "good" high-density lipoprotein (HDL) cholesterol prevents heart disease and stroke.
- VA researchers and colleagues found that a new investigational flu vaccine, delivered via nasal mist, significantly reduced employee absenteeism, doctors' office visits, and medication use in healthy, working adults.
- Researchers from the Memphis, Tennessee, VAMC and the University of Tennessee helped develop a vaccine, which will soon be tested in humans, to prevent diseases caused by streptococci bacteria.

VA's superior performance history in medical research projects is credited primarily to Departmental research management policies.

R&D's policy is to give preference to projects for peer review that fit within one or more of the DRAs. The process to organize and charter a National Research Council was initiated in FY 1998. This council of external advisors examines the research portfolio and recommends appropriate changes or improvements to the DRAs. R&D continues to realign its priority areas to target research projects that address the special needs of veteran patients, and to balance research resources between basic and applied research. This approach ensures a complementary role between new discoveries and the application of these discoveries to medical practice.

Crosscutting Activities

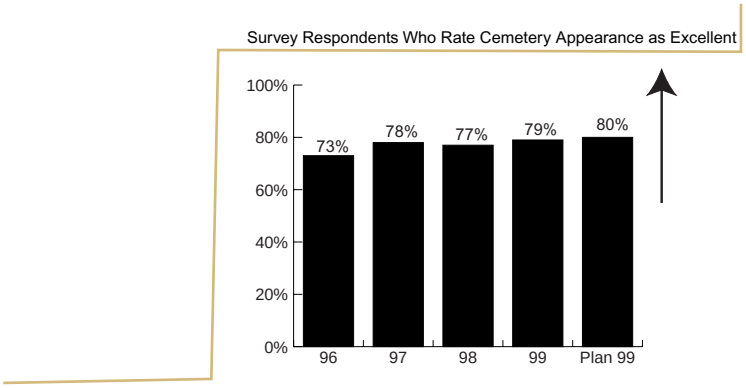
VA researchers participate in a wide range of technical panels and interdepartmental sharing committees. One such example is the National Science and Technology Council's Construction and Buildings Subcommittee on Research and Development. The group's purpose is to lessen the cost of facilities and improve performance. Other examples include the Brain Injury Association and the Defense and Veteran Head Injury Program, which provide additional opportunities to participate in research projects designed to improve the understanding and treatment of traumatic brain injury. VHA's National Center for Clinical Ethics collaborates with its partners at DoD, the Department of Energy, the National Institutes of Health, and the White House to address bio-ethical issues. VA also contributes funds to the President's National Advisory Bio-ethics Committee. VHA's Office of Public Health and Environmental Hazards works with the Nuclear Regulatory Commission and the Institute of Medicine to

conduct research on herbicides, Agent Orange exposure, and the health status of Vietnam-era veterans.

Data Source and Validation
Data are derived from the Research and Development Information System (RDIS). The RDIS is maintained by R&D and is continually updated by the Research Administration Offices at VA health-care facilities. The source of the data is the internal program review files. The validity of the data entry is audited through random R&D administrative site visits. The measure for this goal is the number of projects obtaining renewal compared with the number of projects applying for renewal. A report is produced annually that is national in scope.

Objective 4.5
Ensure that national cemeteries are shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made.

Performance Goal
Increase to 80 percent the number of survey respondents who rate the appearance of national cemeteries as excellent.



VA is committed to assuring national cemeteries are shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of veterans. Our Nation's veterans have earned the appreciation and respect not only of their friends and families, but of the entire country. National cemeteries are enduring testimonials to that appreciation and should be places that veterans and their families are drawn for a dignified burial and lasting memorial.

While we fell just short of the FY 1999 performance goal, customer satisfaction with the appearance of national cemeteries remained at a very high level. The small difference between actual and planned performance had no significant impact on the burial program's success. Cemetery appearance goals are set consistent with the high expectations of veterans and the general public. NCA performance data reflect only excellent ratings.

Means and Strategies
Veterans and their families expect national cemeteries to have well-maintained landscapes, and appropriate, well-cared-for shrubbery and trees. In order to ensure the appearance of cemeteries meets the standards our Nation expects of its national shrines, VA has continued to perform a wide variety of grounds management functions. Headstones were set, aligned, or realigned to maintain uniform height and spacing. Headstones that became soiled were cleaned. To maintain columbaria, VA cleaned stains from stone surfaces, maintained the caulking and grouting between the units, and repaired the surrounding walkways. While attending to these highly visible aspects of our national shrines, VA also maintained roads, drives, parking lots, and walks; painted buildings, fences, and gates; and repaired roofs, walls, and irrigation and electrical systems. Cemetery acres that have been developed into burial areas, and other areas that are no longer in a natural state, also required regular maintenance.

To ascertain how our customers and stakeholders perceive the appearance of national cemeteries, VA annually seeks feedback from them through comment cards and focus groups. The information is used to determine expectations for service delivery as well as specific improvement opportunities and training needs.

Several initiatives are currently underway to ensure consistency of operational definitions, processes, and assessments across the system. New, outcome-based operational standards, aligned with the NCA Strategic Plan and the Departmental Performance Plan, are also being developed. We are consulting with the American Battle Monuments Commission and the Department of the Interior to broaden our perspective and to take advantage of lessons learned. This approach has the added benefit of encouraging consistency across similar government programs.

Crosscutting Activities

VA will continue its partnerships with various civic organizations that provide volunteers and other participants to assist in maintaining the appearance of national cemeteries. An Interagency Agreement with the Bureau of Prisons provides for the use of selected prisoners to perform work at national cemeteries. This agreement has provided a supplemental source of labor to assist in maintaining the national cemeteries. Under a joint venture with VHA, national cemeteries provide therapeutic work opportunities to veterans receiving treatment in the Compensated Work Therapy/Veterans Industries program. The national cemeteries are provided a supplemental workforce while veterans have the opportunity to work for pay, regain lost work habits, and learn new work skills.

Data Source and Validation

The source of these data is the NCA Visitor Comment Card Survey, an annual survey conducted for a period of 90 days. The measure for cemetery appearance is the percentage of respondents who rate the appearance of the cemetery as excellent. Respondents are asked to rate the appearance of cemetery grounds, headstones and markers, gravesites, and facilities. Cemetery appearance is considered the average of excellent scores in each of the four areas rated.

VA headquarters staff oversee the survey process and provide an annual report at the national level. NCA Area Office and cemetery level reports are provided for NCA management use.

5. STRATEGIC GOAL

Provide One VA world-class service to veterans and their families through the effective management of people, technology, processes and financial resources. VA will operate as a veteran-focused organization that provides high-quality, accessible, and timely information and service through the development and maintenance of a high-performing workforce, the application of state-of-the-art technologies, the continuous improvement of processes, and the effective allocation of dollars.

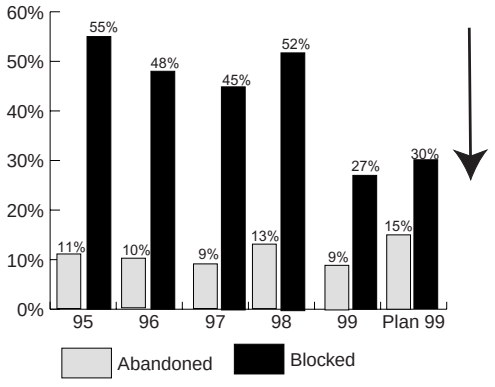
Objective 5.1

Improve communications with veterans, employees, and stakeholders to share the Department's mission, goals, and results, and to increase awareness of benefits and services for veterans and their families.

Performance Goal

Improve communications and outreach by reducing the telephone abandoned call rate to 15 percent and blocked call rate to 30 percent, for calls related to compensation and pension issues.

Abandoned and Blocked Call Rates



VA made a significant improvement in its telephone service during FY 1999. Our abandoned call rate was over 10 percent for each of the first four months of the year, but we reduced it to approximately 7 percent for

each of the last eight months. We improved the blocked call rate even more dramatically. Between October 1998 and January 1999, our blocked call rate ranged between 42 percent and 45 percent. From April through the end of the fiscal year, the rate dropped to a range between 7 percent and 9 percent.

Means and Strategies

The most important reason for our improvement during FY 1999 was implementation of the National Automated Response System (N-ARS). This system serves as the point of entry for customers seeking information and services from any VBA activity. The automated system provides a menu of programmed messages, allowing a caller to access general benefits information. N-ARS also includes an interactive voice response capability. On February 1, 1999, the system was made available to six regional offices with the highest blocked call rates. These offices improved from 60 - 80 percent blocked calls to about 8 percent.

VBA continued the restructuring of its regional offices by combining the adjudication and veterans services activities into consolidated veterans service centers. In this environment, veterans service representatives (VSRs), who are responsible for the combined roles of claims examiners and benefits counselors, interact directly with claimants. Under this configuration, more employees are available to help veterans through our telephone system. By the end of FY 1999, over 75 percent of regional offices had merged their divisions and over 95 percent of their employees were either operating as VSRs or were well into their training.

Data Source and Validation

The abandoned call rate is based on data collected at regional offices using automatic call distribution equipment, which is then entered into the national database. There is no independent validation of this data.

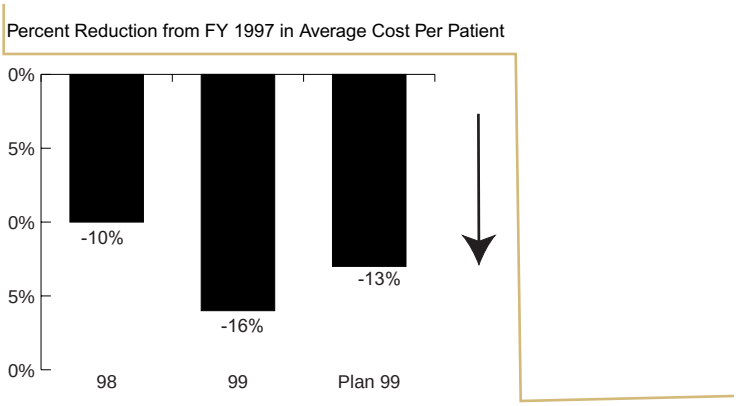
The blocked call rate is based on data collected by the carrier, Sprint, 24 hours a day, 7 days a week, and reported to VA on a monthly basis. VA does not validate the Sprint reports.

Objective 5.4

Improve VA's overall governance and operational management, and access to benefits and services to meet or exceed the expectations of veterans and their families, while ensuring full compliance with applicable laws, regulations, and financial commitments.

Performance Goal 1

Reduce the average cost per patient by 13 percent (FY 1997 baseline = $5,458).



VA exceeded its FY 1999 performance goal for reducing the average cost per patient. The reduction in average cost per patient (or unique social security number) is measured in constant dollars so as to eliminate the impact of inflation.

Means and Strategies

The primary strategy employed to reduce the cost per patient was continuing the reengineering of the health-care delivery system, by shifting health-care resources and patient treatment modalities from inpatient care to outpatient care. This shift impacts physical plants, clinical staff needs, and virtually every other aspect of the system. Hospital utilization was minimized whenever therapeutically possible. Inpatient services were converted to outpatient services and extended into the community. The following spe-

cific strategies were employed successfully by the VISNs to reduce the cost per patient:

- By reducing the number of excess beds and inpatient days of care, VISNs succeeded in shifting inpatient care to various ambulatory locations. Many patients, including long-term psychiatric patients, were transferred to residential care settings. Resource savings from reduced use of inpatient care were used for expanding outpatient treatment programs.

- Consolidation of duplicative services helped networks to expand and improve the quality of care for veterans while reducing unit costs. VISNs also reduced per patient costs by contracting for certain services that VA facilities decided not to provide on an in-house basis. Finally, numerous networks were able to enter into blanket purchase agreements for medical services, which were previously bought on a fee-for-service basis.

- Networks continued to refine the use of various managed care techniques, use drug formularies, and employ clinical pharmacists and other physician extenders as well as market and share excess VA services such as laboratory tests. In short, VA has become more skilled in how to manage care that provides value and satisfaction for its patients.

Crosscutting Activities

VA collaborated with the Department of Health and Human Services to develop non-VA benchmarks for bed days of care, which were obtained from the Health Care Financing Administration's database. We obtained data on ambulatory procedures from the National Center for Health Statistics. VA collaborated with DoD on enhancing VA's Parametric Automated Cost Engineering System in order to partner on real property assets, and to acquire and co-locate VA facilities with excess property available through the closure of military bases. VA also participated in joint design and construction projects with the Department of Agriculture, Indian Health Service, Public Health Service, National Park Service, and Merchant Marine Academy.

In addition, VA provided laundry services to State Veterans Homes and Job Corps Programs. The Department also collaborated with the General Services Administration in a Government-wide Real Property Information Sharing program on utilization of Government-owned and Government-controlled real property in the Northeastern United States, and in the acquisition of leasehold interests in real property for clinical and administrative purposes in various regions across the United States. VA also partnered with a private sector panel to identify enhanced-use lease initiatives at various VA medical centers for the purpose of lowering utility and energy costs.

Major Management Challenges

GAO has identified as a major management challenge whether VA's health-care infrastructure meets veterans' needs. For example, they note the need for consolidation of hospital assets in the Chicago, Illinois, area. VA developed a draft plan for more efficiently meeting the health-care needs of veterans in the Chicago area and has other plans in place to ensure the health-care infrastructure will meet veterans' needs.

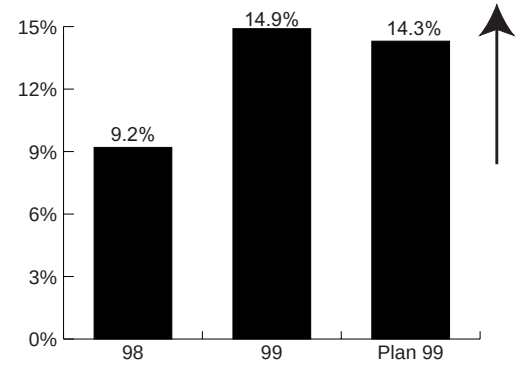
VA has conducted an objective assessment of veterans' health-care needs and existing facility resources for the Chicago metropolitan area. A draft report was completed and sent to stakeholders for comments. A final report will be forwarded to the Under Secretary for Health for his review.

Data Source and Validation

The source of the data on cost per patient is the Automated Allotment Control System (AACS). AACS allocations, which include the prorated share of national specific programs, are compared against the total number of

unique patients. A VISN-specific report is produced annually.

Performance Goal 2
Increase the number of unique patients treated in the VA health-care system by 14.3 percent (FY 1997 baseline = 3,142,000 unique patients).



VA treated 3,610,000 unique patients in FY 1999, exceeding the performance goal of 3,591,000 patients.

Means and Strategies
The 14.9 percent increase from FY 1997 to FY 1999 in the number of unique patients is the result of both continuing demand for care, and skilled management of resources by VA executives, thus making increased access to care possible.

The eligibility reform and enrollment provisions of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, represent the most important external factors in creating the necessary conditions for veterans to have improved access to VA medical care.

In FY 1999, VA employed a number of strategies to broaden access for all categories of eligible veterans. The primary strategy to improve veteran access, and thus increase the number of unique patients treated by VA, has been a gradual shifting of patient care and corresponding resources to ambulatory care programs. The following specific means were used to implement the primary strategy:

- VA implemented primary care policies in all VISNs. The fundamental concept of primary care is to identify and intervene in disease processes and medical problems as early as possible. This often allows for curative care or care that prevents or delays acute and chronic problems. A healthier patient requires fewer resources, thus freeing resources to provide care to more people.
- We increased the number and types of access points for medical care services, especially community-based outpatient clinics (CBOCs).
- The Department expanded panel sizes of primary care teams, adding clinical specialists in mental health and other medical specialties as appropriate, to improve access to a greater variety of services, even in community-based settings.
- We integrated telemedicine technologies into ambulatory care delivery systems (for example, tele-imaging networks for radiology, nuclear medicine, tele-psychiatry, tele-dermatology, and tele-pain management).
- VA increased outreach through mobile vans and participation in health fairs and other community events.
- The Department provided additional liaisons to Vet Centers, shelters, veterans service organizations, and other stakeholders.
- We initiated telephone or mail contact with veterans who have used VA care, but not within the past 12 months.

As a result of current efforts, VA estimates that by FY 2002, 80 percent of high-priority veterans (primarily those with service-connected disabilities) will have improved access to VA health care.

Crosscutting Activities
Numerous sharing agreements with DoD are providing veterans with increased access to quality medical care. Many of these collaborative agreements provide for serious conditions such as spinal cord injury, acute traumatic brain injury, Gulf War llnesses, and a need of prosthetic services. In cooperation with the Department of Health and Human Services, VA continued to evaluate progress/results of DoD Medicare subvention with the goal of designing a VA subvention pilot. These veterans are defined as those who have income or assets above the VA means test threshold; they are either service-connected veterans at the zero percent level (non-compensable) or non-service-connected veterans.

Major Management Challenges
Previous audits by VA's Office of Inspector General (IG) indicated resource allocations, i.e., VHA funding patterns, have not been adequately addressed. VHA has corrected resource and infrastructure imbalances by changing the method used to fund VA networks. This methodology, called Veterans Equitable Resource Allocation (VERA), implemented in April 1997, allocates funding based on workload (patients treated), rather than on incremental increases to prior year allocations. A field-based workgroup has evaluated network-to-facility allocation methodologies and has identified, summarized, and distributed them to networks for best practices use. The transition to VERA-based funding will be completed in FY 2002.

GAO has advised the Secretary to direct the Under Secretary for Health to send Congress a report that presents the overall VA plan and time schedule for the system-wide establishment of access points. This report should assist Congress in determining the affordability of the plan. While reviewing this GAO recommendation, VHA has agreed to have the 22 VISNs develop strategic plans that will serve the same purpose as that envisioned by GAO, therefore obviating the need for a separate report. The network plans are consolidated into a national business plan, which includes activities relating to the establishment of access points. Equity in access has already been addressed to a large degree by the ongoing establishment of CBOCs.

In response to other GAO recommendations regarding access to health-care services, VA has taken the following actions:

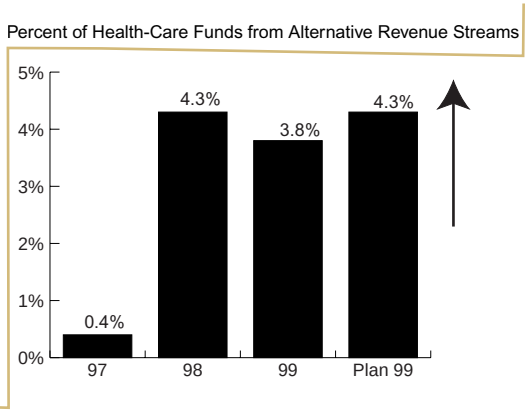
- ❑ Developed a tracking system to monitor complex care workload relating to VERA funding allocations;
- ❑ Developed a review process for allocations by network directors to the medical centers;
- ❑ Implemented enrollment procedures for gathering and updating information on employment, insurance, and service-connected disabilities;
- ❑ Agreed to identify a minimum criteria set for all networks focusing on evaluation of outcomes.

Data Source and Validation
The source of these data is the VERA Patient Database located at the Boston Allocation Resources Center (ARC). A report on the number of unique patients is produced annually and is available at the national level and for each of the VISNs. VHA devotes considerable effort to ensure the information provides a comprehensive picture of the patient population. At the end of each fiscal year, the ARC evaluates all data sources and checks for validity and reliability; for example, it removes duplicate and invalid records. There are many automated procedures throughout VHA's data collection systems to ensure the social security number of each patient is accurately recorded and entered into the local and national patient count only once during a fiscal year. Due in part to IG rec-

ommendations stemming from an independent evaluation of the data system, VHA is implementing edit checks (designed by VA's Austin Automation Center) in automated data processing systems to identify and correct input errors, thus improving the quality of data used to report the number of unique patients. In addition, a major enhancement to the Veterans Health Information Systems and Technology Architecture is a primary VHA initiative to address input errors cited in the IG audit. The Clinical Information Resource Network/Patient Demographics module currently being implemented throughout the system provides the necessary tools to identify potential patient duplicates, and requires facilities to correct errors before processing can be completed.

Performance Goal 3

Increase to 4.3 percent the share of the medical care operating budget derived from alternative revenue streams, such as medical cost recoveries, Medicare, and other sharing revenues.



Although the Department did not meet the FY 1999 goal, the share (3.8 percent) of the medical care budget coming from alternative revenue streams was actually higher than in FY 1998. The percentage in FY 1998 was artificially inflated and would have been 3.4 percent if collections credited from the last quarter of FY 1997 and a one-time Treasury supplement were excluded.

VA's overall strategy proposed that by FY 2002, 10 percent of the medical care operating budget would be derived from alternative revenue streams. This was predicated on receipt of Medicare monies as a major source of non-appropriated funds. However, Congress has not yet approved a Medicare subvention proposal, which would allow VA to bill Medicare for the cost of providing health care to certain Medicare-eligible veterans. As a result, VA had to revise downward its projections for FY 2000 and FY 2001.

Means and Strategies

VA actively pursued various revenue strategies, including making improvements in medical cost recoveries, to increase reimbursements for services from $92.3 million in FY 1998 to $103.3 million in FY 1999. Additionally, we attempted to obtain approval from Congress for a Medicare reimbursement pilot initiative. While unsuccessful in gaining Medicare subvention pilot authority to date, VA will continue to evaluate preliminary results of DoD subvention to design a sound VA subvention pilot. The changes made in the VA health-care system since 1994 demonstrate that the infrastructure and processes are in place to enable VA to meet Medicare and other insurer requirements.

A variety of strategies will be used to maximize the share of the medical care operating budget derived from alternative revenue streams, including:

- ❑ Implementing reasonable charges, to allow market price recoveries for actual services provided.
- ❑ Establishing patient pre-registration at medical facilities to ensure accurate insurance information, including the use of software to assist in gathering and updating patient insurance information.
- ❑ Pursuing outsourcing opportunities for all or part of the revenue process.
- ❑ Scanning outpatient encounter forms and using outpatient procedure rates to increase outpatient recoveries.

In FY 1999, VISNs used local strategies for increasing alternative revenue streams. For example:

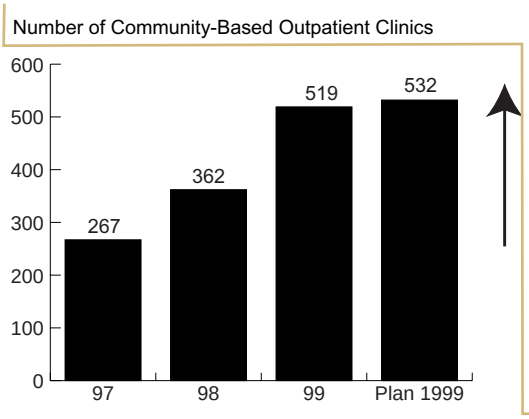
- A number of networks established a Network Alternative Revenue Team Coordinator position or function. This strategy ensures collection objectives are regularly monitored, and persistent problems receive timely management attention.
- Networks acquired billing software, increased insurance positions, conducted pre-registration, entered into agreements with other networks for telephone triage services, hired a collection agency to follow up on bills greater than 90 days past due on a network-wide basis, and designated a site-specific insurance expert to clean up insurance files.
- The strategy of selling excess capacity was used to supplement appropriated funds. A number of networks sold ancillary medical and travel services, entered into joint ventures, or utilized enhanced-use contracts.
- We established a national pilot, with three VISNs participating as alpha sites, to have our TriCare billing/collection processes and business practices independently audited by an external consultant.
- We better informed veterans, employees, and veterans service organizations about third-party billing, and developed training for physicians and coders.

Crosscutting Activities
VA worked closely with the Department of Health and Human Services, and subsequently submitted a legislative proposal to enable VA to receive payment for the treatment of Medicare-eligible, higher income, non-service disabled veterans who were provided care under VA auspices.

Data Source and Validation
The source of this data is the General Ledger maintained by VHA's Office of Financial Management and the AACS. The measure for this goal is calculated from revenue figures recorded in each VISN's general ledger compared against VISN current year availability without unobligated balances from the prior year.

Audit programs, as mandated in the Chief Financial Officers Act and the Federal Financial Managers' Integrity Act, help to ensure the validity and reliability of these figures.

Performance Goal 4
Increase to 532 the number of community-based outpatient clinics at which veterans and eligible dependents can receive outpatient care.



These figures include CBOCs established before 1995, as well as multiple access points established by some providers under a single contract.

VA's goal is to improve veterans' ability to access the offices, facilities, and services of the Department and to make available to all VA employees the most up-to-date information on individual veterans, so that veterans can be provided specific information on the spot. VA has disseminated information, such as pamphlets and brochures, on programs, benefits, and services. Data and information will be accessible, timely, and accurate.

Means and Strategies
VA fell just short of the FY 1999 goal. Future target levels are not expected to be affected by this slight shortfall. Nevertheless, the number of CBOCs in FY 1999 was 43 percent higher than the count a year earlier. During FY 1999, an additional 75 CBOCs were approved for implementation in the next few years. These approvals represent over half the

number of CBOCs needed to achieve the strategic goal of 659.

Achieving this goal will go a long way toward providing equitable access for all enrolled veterans. Any veteran will be able to receive comparable treatment for an illness or disability at more locations throughout the country. Further, VA estimates that by the end of FY 2002, 80 percent of high-priority veterans (principally veterans with service-connected conditions) will have improved access to health care, due in large part to the establishment of CBOCs.

Headquarters worked closely with veterans' representatives, VA field staff, and Congressional representatives in planning for acceptable facility sites. The role of the modern VA CBOC system is still evolving, and new services are added as necessary. Not all CBOC locations are under direct VA supervision. The specific management model is determined locally.

In the past fiscal year, VISNs used a variety of approaches to improve access through the addition of new CBOCs. The following were the most frequently reported approaches:

- ❑ Networks consistently educated their staff and veteran customers about new CBOCs. For example, some issued videos; prepared marketing booklets; established planner positions; conducted market analysis studies; and developed outreach programs through direct mail, visits to prisons, health promotion, and newsletters.

- ❑ A number of networks emphasized their CBOC planning programs, and established methodologies, policies, and other criteria and data needs for CBOCs on a VISN-wide basis.

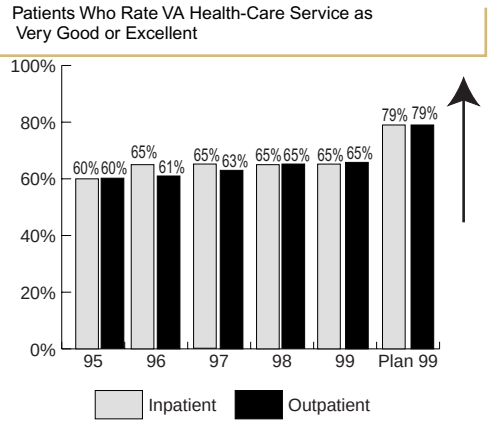
- ❑ Networks developed and tested evaluation criteria and parameters for assessing effectiveness of VISN CBOCs in meeting objectives.

Crosscutting Activities
VA policy encourages VISN managers to enter into various types of community arrangements to provide comprehensive medical care for veterans in remote areas and closer to their homes. A good example of this is co-location of clinic space with State Veterans Homes. VA also contracts for community providers serving veterans close to their homes.

Major Management Challenges
The opening of CBOCs is generally financed out of existing funds. Locally, new financing is made possible by shifting funds from inpatient to outpatient activities, in this case into CBOC operations. VISN executives have designed balanced inpatient and outpatient treatment programs that will continue to be monitored, as in the past, to ensure value for the taxpayer-supplied health-care dollars.

Data Source and Validation
VA conducts periodic surveys (compiled by VHA network support staff) to identify and verify the current number of existing and proposed CBOCs. In addition, one can examine CBOC workload reports, relevant Congressional correspondence on new clinic proposals, and the history of station numbers issued by VA headquarters for activated CBOCs, which validate the number of CBOCs in operation. In order to streamline this complex validation process, VHA is developing an automated database. If approved, the database will serve as the sole source for identifying and counting CBOCs and other VA medical facilities.

Performance Goal 5
Increase to 79 percent the number of patients rating VA health-care service as very good or excellent.



During the last three years, the share of inpatients and outpatients rating VA health-care service as very good or excellent has remained stable at about two-thirds. This satisfaction level is well below the target level of performance established at the beginning of FY 1999. The performance goals were the best estimates that could be made based on the few data points available at the time they were provided, and future target levels of performance for this measure will be adjusted to be more consistent with actual past achievement.

A variety of data sets are available on the satisfaction of patients using VA health-care service. Among the most important of these is information recently released in conjunction with a nationwide survey commissioned by the National Partnership for Reinventing Government (NPR). The NPR study used the American Customer Satisfaction Index (ACSI) as a national indicator of customer evaluations of the quality of goods and services. It is the only uniform cross-industry/government measure of customer satisfaction, and allows benchmarking between the public and private sectors. Data on veterans' satisfaction with their health-care service is based on a sample of veterans who used VA outpatient services during the first two weeks of May 1999.

The 1999 ACSI for VA outpatient care is 79 on a scale of 0 to 100. This is 10 points above the score logged by private sector hospitals, and 7 points higher than the current national ACSI recorded by the general public for all industry sectors. Of particular note is VA's index of veteran loyalty, (90). Well above the loyalty score (68) registered by private hospitals, this score is based on the very high degree to which VA patients indicate they will use a VA medical center (VAMC) in the future and the extent to which they would be willing, if asked, to say positive things about VAMCs. In addition, VA patients expressed much greater satisfaction with the health-care service they received in 1999 when compared to the service they received two years ago.

Means and Strategies

VA is constantly seeking feedback from customers on their satisfaction through surveys, focus groups, complaint handling, direct inquiry, and comment cards. This feedback has led to the development of an important database on what customers expect and experience. This information assists VA leaders in deciding which performance goals to revise, and in identifying areas in which service improvements are required. As appropriate, specific groups of customers, such as spinal cord injury respondents and blind rehabilitation patients, are surveyed to determine their special needs and levels of satisfaction.

In FY 1999, networks used a variety of strategies to ensure veterans were satisfied with their health-care service, including: enhancing provider/patient communication through education programs; using post-discharge telephone calls, quick cards, and patient representative visits for new admissions; utilizing product line managers to resolve complaints; instituting a quarterly awards program at each facility to recognize outstanding employees; giving patients the provider treatment roster; routinely surveying staff and patients to head off emerging problems and reinforce positive trends.

A variety of local strategies continued to be employed to improve patient access to care, including: opening new CBOCs and com-

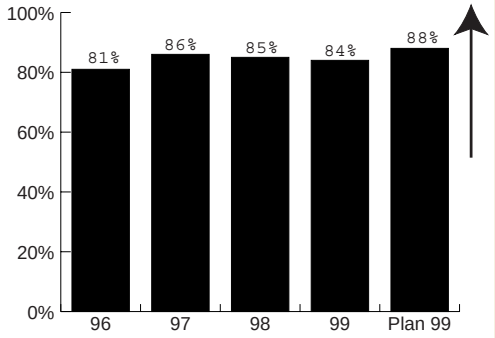
munity service centers; opening weekend clinics; employing case managers; building permanent clinic screening teams; and making infrastructure improvements such as a Guest Services Program.

Crosscutting Activities
VISNs constantly seek input from veterans service organizations and cooperate with them to ensure access, reduce friction, and improve quality of care, all of which lead to greater satisfaction with VA medical services.

Data Source and Validation
The source of data on the percent of patients who rate VA health-care service as very good or excellent is the National Performance Data Feedback Center. This center, formerly the National Customer Feedback Center, began gathering data from inpatients on satisfaction in 1994, and from outpatients in 1995. After assessing samples from inpatients and outpatients, VA reports the findings annually on a nationwide and VISN-specific basis. The inpatient survey targets a random sample of veterans who were recently discharged from inpatient care. The outpatient survey is sent to veterans who had at least one outpatient visit at the general medicine clinic, primary care clinic, or women's clinic. At each clinic, 175 veterans were randomly selected. Clinics with fewer than 50 eligible veterans were excluded from the survey sample. The validity and reliability of the findings are ensured by the application of standardized survey research techniques, i.e., identical methods are used in all settings. This is a major strength of the VA survey process. It allows comparison of results at the facility level. The survey response rates are very high, thus leading to more reliable information. In addition, VA survey instruments use many of the same questions as the Picker Institute in the private sector, therefore allowing valid comparisons with non-VA satisfaction results.

Performance Goal 6
Increase to 88 percent the number of survey respondents who rate the quality of service provided by national cemeteries as excellent.

Survey Respondents Who Rate Quality of Service as Excellent



Our goal is to make sure the Nation's veterans and their families are satisfied with the cemetery services provided by VA. The Department strives to provide high-quality, responsive service in all of its contacts with veterans and their families.

While we fell short of the FY 1999 performance goal, satisfaction with the quality of service provided by NCA remained at a very high level. The small difference between actual and planned performance had no significant impact on the burial program's success. Cemetery service goals are set in keeping with the high expectations of the families of individuals who are interred in national cemeteries and of other visitors. NCA performance data reflect only excellent ratings.

Means and Strategies
In order to improve service to veterans and their families, VA provides weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. In FY 1999, VA provided weekend scheduling for over 3,700 interments.

Kiosk information centers assist cemetery visitors in finding the exact gravesite location of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the National Cemetery Administration. By the end of FY 1999, kiosks had been installed at 13 national cemeteries.

Veterans and their families have indicated the importance of knowing the interment schedule as soon as possible so the family may finalize necessary arrangements. The time it takes to mark the grave after an interment is also extremely important to the veteran's family members. To meet these expectations, VA plans to schedule committal services at national cemeteries within two hours of the request and set headstones and markers at national cemeteries within 60 days of the interment. Data collection instruments, using modern information technology, have been developed to measure the timeliness of interment scheduling and the setting of headstones and markers at national cemeteries. NCA has chartered a quality improvement team to assess data collection procedures and make recommendations to ensure data collected for these two measures are accurate, valid, and verifiable.

To ascertain how our customers and stakeholders perceive the quality of service provided by national cemeteries, VA annually seeks feedback through comment cards and focus groups. This information is used to determine expectations for service delivery, as well as specific improvement opportunities and training needs. VA will continue to conduct focus groups to collect data on stakeholder expectations and their level of satisfaction with NCA services. The information gathered will be used in the NCA strategic planning process to develop additional strategies for improving service.

Crosscutting Activities

VA has worked closely with components of DoD and veterans service organizations in providing military honors at national cemeteries. While VA does not provide military honors, national cemeteries facilitate the provision of military honors and provide logistical support to military honors teams. Veterans and their families have indicated the provision of military honors for the deceased veteran is important to them.

VA continued to work with funeral homes and veterans service organizations to find new ways to increase awareness of benefits and services. Funeral directors and members of veterans service organizations participated in focus groups to identify not only what information they need, but also the best way to ensure they receive it.

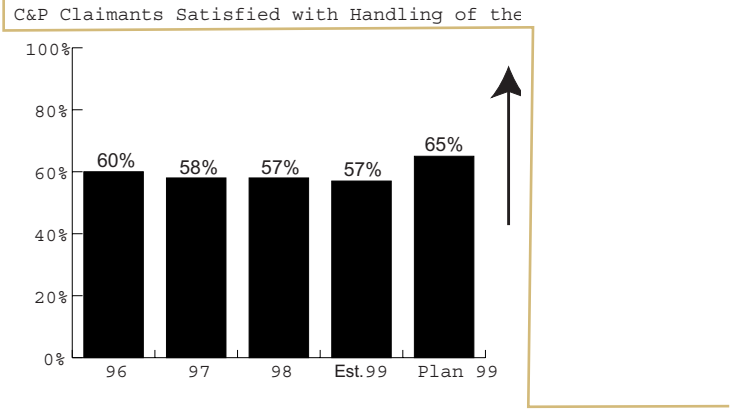
Data Source and Validation

The source of data used to measure the quality of service provided by national cemeteries is the NCA Visitor Comment Card Survey, an annual survey conducted for a period of 90 days. The measure for quality of service is the percentage of respondents who rate the quality of interaction with cemetery staff as excellent.

VA headquarters staff oversee the survey process and provide an annual report at the national level. NCA Area Office and cemetery level reports are provided for NCA management use.

Performance Goal 7

Increase to 65 percent the number of compensation and pension claimants satisfied with the handling of their claims.



Performance information about customer satisfaction with C&P claims processing will not be available until mid 2000. However, we estimate it will be approximately the same as last year's rate of 57 percent. Although we do not know the level of customer satisfaction with service delivery during FY 1999, we

realize that veterans are not completely satisfied with some areas of our decision-making process. We believe the improvements we are making in those areas will lead to improvements in this measure.

Although we do not yet have data from our own comprehensive survey of veterans, we do have general information from the recently released nationwide survey on customer satisfaction commissioned by NPR. The NPR study used the ACSI as a national indicator of customer evaluations of the quality of goods and services available to United States residents. It is the only uniform cross-industry/government measure of customer satisfaction, and allows benchmarking between the public and private sectors. Data on veterans' satisfaction with compensation claims processing is based on a sample of veterans who received decisions during May 1999. Data from our own National Survey of Customer Satisfaction will provide us with a more complete assessment of our progress in improving customer satisfaction in 1999. The NPR survey reported an index score of 61 out of 100 for claims processing, which is consistent with the results from previous VA surveys. The average private sector score on the index is 72.

This performance measure also supports our objectives to:

- ❑ Ensure survivors of service-disabled veterans are able to maintain a minimum standard of living and income through compensation and education benefits.
- ❑ Provide a level of income that brings eligible wartime veterans and their survivors up to a standard of living that ensures dignity in their lives.

Means and Strategies

The reengineered claims processing environment for C&P includes more frequent, personal, and proactive contact between VA employees and claimants or their service representatives. As claimants interact more directly with VA personnel processing their claims, we are able to improve the quality of service and information claimants expect. The new Information Center and the following C&P initiatives implemented in FY 1999 will contribute to future performance improvements:

- ❑ Additional FTE resources
- ❑ Conversion to Service Centers
- ❑ Out-based Customer Service Centers
- ❑ Nationwide implementation of Training, Responsibilities, Involvement, and Preparation (TRIP)

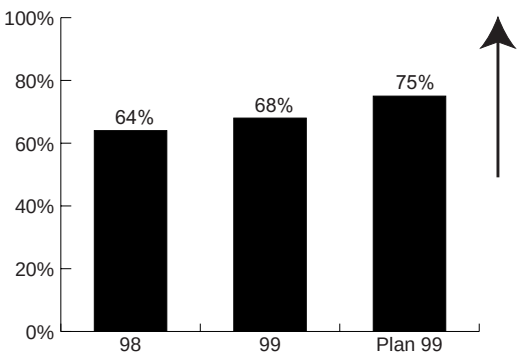
As we take action to add employees to the decision-making process, improve technical accuracy, and further develop our employees' skills, we anticipate improvements in customer satisfaction. Traditional adjudication and veterans assistance divisions are being blended into Service Centers. This new structure provides closer contact with customers. The traditional veterans claims examiner and benefits counselor positions are being merged into a single position, which will improve ownership of claims and a better understanding of customers' concerns. Case managers will have the authority to interact with veterans, identify and resolve issues, and make decisions at the earliest opportunity. Out-based Customer Service Centers allow more claimants to interact directly with VA personnel responsible for processing their claims. In addition, we implemented a Customer Service Improvement Team to identify customer satisfaction improvement opportunities and best practices at the local level, and methodologies for determining the impact of those improvement opportunities.

Data Source and Validation

The percent of C&P customers satisfied with the handling of their claim is determined through the annual Survey of Veterans' Satisfaction with the Compensation and Pension Claims Process. VBA's Surveys and

Research staff oversees the survey process to make sure professional standards are met and reliable results are obtained.

Performance Goal 8
Obtain a 75 percent national accuracy rate for core rating work.



The FY 1999 performance goal for the national accuracy rate for core rating work was based on program judgment that, given the baseline accuracy level of 64 percent, considerable improvement should be experienced during the first year of the revised accuracy review program. Our actual performance of 68 percent was an improvement compared to the baseline. However, the anticipated learning curve associated with implementation of initiatives to improve accuracy took longer than projected, and we failed to achieve the performance goal. We initially had difficulties in disseminating to regional offices the gap analysis data needed to identify areas requiring training.

Core rating work includes the following types of claims: original compensation, original pension, original dependency and indemnity compensation, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. This work represents the most difficult and time-consuming activities confronting regional office staffs.

This performance measure also supports our objectives to:

- ❑ Ensure survivors of service-disabled veterans are able to maintain a minimum standard of living and income through compensation and education benefits.
- ❑ Provide a level of income that brings eligible wartime veterans and their survivors up to a standard of living that ensures dignity in their lives.

Means and Strategies
Our most important step in improving quality was to establish technical accuracy as our number one priority. This is the most important element on the VBA balanced scorecard for C&P claims processing.

In FY 1999, VA implemented the Systematic Technical Accuracy Review program nationwide. The program helped improve the accuracy of C&P claims by providing current information about the accuracy of work being produced at field stations. This information assists in the identification of training needs and other interventions designed to improve quality.

Training is a key element in our drive to improve accuracy. As part of our Training and Performance Support Systems (TPSS) initiative, we have made available to all employees five interim, updated training packages and four interactive training modules. We have extensive data that show TPSS training results in a large increase in rating accuracy. As we enhance this training and more employees complete the modules, we expect significant improvements in our accuracy rates.

Major Management Challenges
The Department has two major management challenges that affect achievement of this performance goal: the increased complexity of the workload and the loss of highly experienced decision-makers.

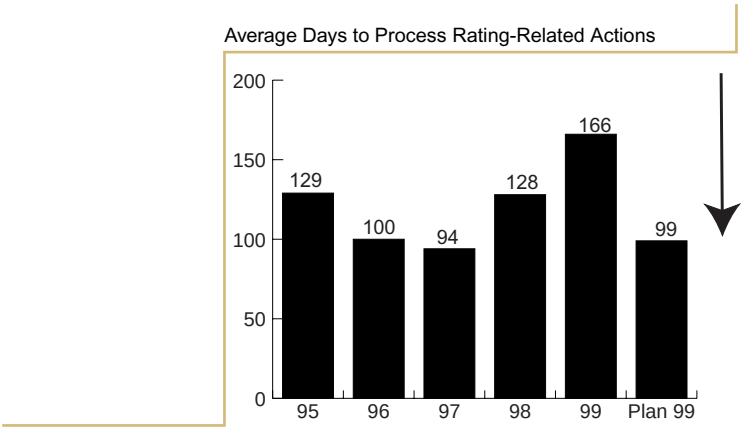
Decision-makers are faced with significant changes in the body of law governing compensation and pension programs. Compared with the past, the process of evaluating

claims, using a combination of regulations and precedent decisions, is much more complex, requires additional research time, and is more prone to error.

During the next five years, VA will experience the loss of over 1,100 experienced decision-makers due to retirement. To avoid a two- to three-year skill gap, we need to stabilize the claims processing workforce by hiring and training a substantial number of new employees before the actual losses occur.

Data Source and Validation
To determine rating accuracy, the C&P Service established an independent quality review staff to assess a sample of completed cases for each service delivery network. The national accuracy rate is calculated from these samples, which are large enough to allow for a 95 percent confidence level and an error rate of +/-5 percent.

Performance Goal 9
Complete rating-related actions on C&P claims in an average of 99 days.



VA realizes that timeliness of claims processing, especially rating-related actions, is an important issue and we acknowledge current performance is unacceptable. We have a number of significant initiatives underway to help us improve our performance in the future. These are discussed below under means and strategies.

Rating-related actions include the following types of claims: original compensation, original pension, original dependency and indemnity compensation, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. These represent the most difficult and time-consuming areas confronting regional office staffs. The timeliness measure for rating-related actions also supports our objective to provide a level of income that brings dignity to eligible wartime veterans and their survivors by ensuring a decent standard of living.

We missed our FY 1999 target by a substantial margin for several reasons:

- The target was based on performance of a small number of field stations with the best timeliness. Expecting all stations to perform at that level was unrealistic.
- Because of our concern with the quality of decision-making, we shifted emphasis away from timeliness toward quality. We asked claims processors to take a closer look at the way they process claims and to write better decisions. This adversely affected timeliness.
- Compared with the recent past, claims processing is a more complex activity because of decisions by the Court of Appeals for Veterans Claims and changes in the nature of veterans' disabilities.
- While we expected some performance slippage as we implemented many initiatives in our regional offices, we did not anticipate their full effect. We also did not anticipate the magnitude of the training requirements as we implement our initiatives.
- The quality of our data is much better. While improving data reliability has not directly worsened performance, it can make it appear so. We have serious doubts about the accuracy of data before FY 1999. Data accuracy is now a Department priority.

Although we did not achieve our FY 1999 target, we believe we have in place the appropriate organization and are pursuing a set of strategies that will lead to dramatic improvements in claims processing across our full set of performance measures for C&P claims.

Means and Strategies
VA has many initiatives underway to improve claims processing performance. The most important ones for reversing the timeliness trend are discussed below.

Throughout the fiscal year, regional offices were merging their adjudication and veterans services activities into veterans service centers. Under this organization, case managers have the authority to interact with veterans, identify and resolve issues, and make decisions at the earliest possible opportunity without hand-offs. In this environment, we have forged partnerships with service organization representatives to provide them with the tools they need to help veterans submit claims that need less development by VA.

During the last two fiscal years, VBA shifted staff and other resources to claims processing, primarily from veterans assistance, loan guaranty, information technology, and other support functions.

Critical elements of the reengineered vision are the performance of claims development and disability examinations, and the preparation of rating decisions for service persons awaiting discharge from active duty. During FY 1999, approximately 9,000 claims were processed for individuals separating from 18 of the largest military separation points in the United States.

Crosscutting Activities
VA worked closely with DoD and the National Personnel Records Center (NPRC) to make sure we received service records as soon after separation as possible, so we would not incur any unnecessary delay while awaiting receipt of records. The Personnel Information Exchange System component for requesting records and service verification from NPRC was implemented in December 1998.

Major Management Challenges
GAO and the IG report that timeliness of adjudication decisions and slow appellate decisions continue to be major challenges in VA's compensation and pension programs. VA has taken several steps to address these challenges. VBA continues to pursue the redefined claims processing concepts outlined in its "Roadmap to Excellence." Nine Service Delivery Networks (SDN) were established to align regional offices geographically, enabling the offices in each network to share resources and provide support to each other.

Also among the outlined concepts is the continued merger of veterans services functions with adjudication functions into veterans service centers where a case manager approach will be used for completing claims for veterans benefits. Although this merging of functions adversely affects our ability to complete claims in the short term, the long-term effect will be the ability to provide more timely and accurate service to our customers.

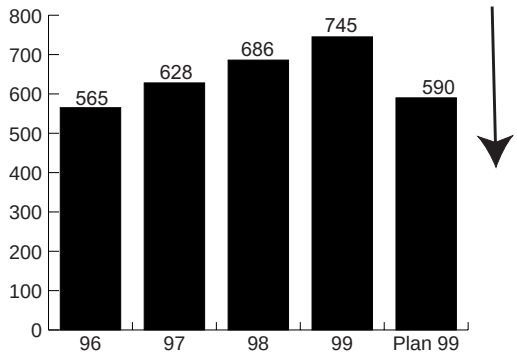
Data Source and Validation
The timeliness of rating-related actions is measured using data captured automatically by the Benefits Delivery Network as part of claims processing.

In its September 1998 report, the IG found three key C&P timeliness measures lacked integrity. They reported the information system was vulnerable both to reporting errors and to manipulation by regional office personnel to show better performance than was actually achieved. VA has taken several steps to ensure the accuracy and reliability of its data. Since October 1997, we have maintained a database of all end-product transactions which are analyzed, on a weekly basis, and use this information to identify questionable actions by regional offices. The C&P

Service reports quarterly on its findings and calls in cases for review from stations with the highest rates of questionable practices.

Performance Goal 10
Reduce appeals resolution time to 590 days.

Appeals Resolution Time in Days



Although appeals resolution time was developed and adopted in October 1998, performance figures for earlier years are included to provide context for this new measure.

Appeals resolution time was adopted at the beginning of FY 1999 as a principal measure of the overall length of time it takes VA to handle all types of claims. Adopted jointly by the Board of Veterans' Appeals (BVA) and VBA, appeals resolution time takes into account cases resolved by either a final regional office decision or Board determination. This measurement, expressed in days, is a composite average of the elapsed time from Notice of Disagreement receipt through resolution, wherever that may occur. Not included are cases returned to the Department as a result of a remand action by the U. S. Court of Appeals for Veterans Claims.

Means and Strategies
Although some improvements in timeliness can be achieved unilaterally by BVA, such as those realized from reductions in administrative overhead and other initiatives involving internal procedural changes, others can result only from coordinated efforts undertaken by both BVA and VBA. Such an approach acknowledges that claims and appeals processing must be viewed as a continuum, rather than as a series of discrete activities. VA is committed to this approach; both BVA and VBA are working to reduce the appeals resolution time.

For 1999, the performance goal was to reverse the current upward trend and reduce the appeals processing time to 590 days. However, due in large part to the continuing high remand rate (i.e., cases returned for redevelopment), this goal was not achieved. Because actual performance of 745 days is significantly higher than the goal, the FY 2000 target has been changed from 545 days to 670 days.

There continues to be a large volume of remands pending in the field. During FY 1999, VBA reduced the number of pending remands by either granting the benefits or returning the cases to the Board. Remands represent a rework phase of the appellate cycle and typically add two years to the processing time for an appeal. Remands delay more than the individually affected cases. Because, by law, we must process the oldest cases first, processing of newer appeals is delayed when remanded appeals are returned to the Board for readjudication. Also contributing to the increase in timeliness was a greater emphasis on quality. These factors resulted in the Board's elapsed processing time increasing by 20 days per case.

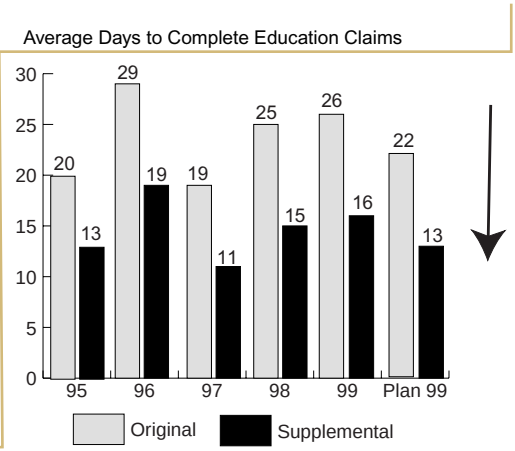
Success in reducing the appeals resolution time and achieving our goal will require qualitative improvements in VA's appellate operations. Remand rate reduction is a central component of VA's strategy for reducing the appeals resolution time. One of our primary remand rate reduction strategies is to improve appellate processes through information sharing between BVA and field adjudication staff, using regularly scheduled information exchange sessions conducted via interactive videoconference systems. A second strategy is to develop and refine improved bases of information to better analyze trends concerning what types of cases have been remanded and why, in an effort to avoid future remands. Working with VHA, BVA has established a medical opinion program to alleviate the need to remand in

instances where additional medical information is needed.

Data Source and Validation
The Veterans' Appeals Control and Locator System, VA's appeals tracking system and BVA's main business system, served as the exclusive source of all data used to compute appeals resolution time.

Where feasible, edits have been built into the system to prevent data entry errors. There are checks and balances throughout the system to detect errors, and procedures in place to correct them.

Performance Goal 11
Process original and supplemental education claims in an average of 22 days and 13 days, respectively.



While our plan was to process original claims in no more than 22 days, it took an average of 26 days. Supplemental claims processing timeliness slipped to 16 days, or three days over the performance target. This slippage is due in large part to technical difficulties encountered by the regional processing offices in Atlanta and St. Louis during the imaging conversion. Significant start-up problems associated with the conversion hampered claims processing during fall enrollment periods (July-August). St. Louis was able to recover in a shorter time frame because the station was merely converting from one image-enabled environment to another. Atlanta's problems were compounded by a much steeper learning curve in converting from a paper-based environment to an image-enabled one.

Our past experience in establishing measures and targets relative to the education program is reflected in the realistic FY 1999 targets, and our success in working toward them. Our inability to meet some of the targets is the result of difficulties experienced in consolidating telephone traffic to specific locations and the conversion to a new phone system. The technical problems we experienced required a shift in resources, which impacted many of the VBA performance scorecard measures. Our processing centers demonstrated the flexibility needed to handle unexpected adversities and the ability to minimize their impact on workloads.

Means and Strategies
During FY 1999, VA tested two interactive Internet applications designed to improve service to veterans and facilitate information exchange between VA and education and training institutions. The Web Automated Verification of Enrollment will allow MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form to VA. By eliminating mail time, veterans will receive their monthly benefits more quickly. The second application, VA Internet Certification, will provide an Internet vehicle for school certifying officials to submit student enrollment information to VA. Both applications will reduce the amount of paper coming to the regional processing offices (RPOs) and speed the benefit payment process.

By August 1999, The Imaging Management System (TIMS) was operating in three RPOs. TIMS will be installed in the fourth RPO, Buffalo, in FY 2000. Imaging has many benefits. It reduces dependency on paper and allows the submission of electronic enrollment information from training institutions directly into the system. It then goes immedi-

ately to claims examiners for processing. By reducing the number of times information is handled, delays in processing caused by misrouting are eliminated. The result is fewer inquiries; those received are resolved more quickly.

The early phases of EDI/EFT (electronic data interchange/electronic funds transfer) were implemented. Beneficiaries under the MGIB-Active Duty (Chapter 30) program can have their monthly benefit deposited electronically into the account of their choice. Almost 60 percent of them do so. By the end of FY 2000, beneficiaries under the MGIB-Selected Reserve (Chapter 1606) will also be able to request EFT. Participation is expected to be high. As a result of EFT, the funds are available to them three to five days earlier than if they received a check. In addition, some enrollment information received electronically from educational institutions is processed entirely by the prototype rules-based expert system, without human intervention. Results from the prototype system have indicated that with an extensive outreach effort to school officials, plus improvements in the education payment systems and development of a comprehensive expert system, up to 90 percent of all education claims can be processed automatically.

Data Source and Validation

The education timeliness is measured using data from a central management information system and the Distribution of Operational Resources system. Education service personnel in VA headquarters validate reported data during regular quality assurance reviews.